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8

Population pharmacokinetics of infliximab in patients with inflammatory bowel disease: potential implications for dosing in clinical practice

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Abstract

Background

Infliximab (IFX) is effective in the treatment of inflammatory bowel diseases (IBD). Currently IFX is administered at fixed doses and intervals, however costs are high and optimization is necessary. Several publications indicate that IFX should be dosed on trough levels $\geq 3.0\text{mg/L}$. For optimizing IFX dosing, the use of a pharmacokinetic model is important. Population pharmacokinetics of IFX have been described earlier, however these models were not used for dose optimizing.

Aim

To develop a pharmacokinetic model for IFX in IBD patients that can be used for dose-optimization of IFX and to predict serum trough levels in this population.

Methods

An observational retrospective study was performed in 42 IFX treated IBD patients. Serum samples were drawn before infusion at $T=0, 2, 6, 14, 22$ and 54 weeks and analysed for IFX and antibodies against IFX (ATI). Relevant covariates were recorded and a population pharmacokinetic model was developed.

Results

Individual plots created using the final model showed good correspondence between observed and model predicted values. Serum levels were influenced by ATI, disease activity, sex and albumin. Our results show that in patients without ATI target trough levels $\geq 3.0\text{mg/L}$ can be achieved by increasing dosing intervals from 8 to 12 weeks combined with a dose-increase. This results in 33% reduction in concomitant costs.

Conclusion

In IBD patients without ATI, trough level dosing based on longer intervals can reduce IFX-therapy related visits to the hospital with one third. Trough level based dose intensification should always be justified by disease activity parameters.

Introduction

Infliximab (IFX), a chimeric mouse-human monoclonal antibody against tumor necrosis factor alpha (anti-TNF-alpha) has proven to be effective in the treatment of inflammatory bowel diseases (IBD) i.e. Crohn's disease (CD) and ulcerative colitis (UC) not responding to conventional therapy. IFX is effective in inducing and maintaining remission of luminal and fistulizing CD and UC.¹⁻⁴ Anti-TNF-alpha agents are administered at fixed doses and fixed intervals derived from dose finding studies.^{4,5} Measuring IFX and antidrug antibodies against IFX (ATI) levels is not common practice and until recently dose-intensification was only based on clinical evaluation of the disease which appeared to be often inaccurate.⁶⁻⁸

In the literature several studies demonstrated a relationship between IFX drug concentrations, the presence of ATI and clinical outcome.⁹ Episodic IFX treatment in patients with CD has been associated with a higher rate of ATI as compared with scheduled maintenance therapy.¹⁰ Patients on IFX therapy who develop ATI have a threefold higher increased risk of loss of response to therapy compared to those who do not develop ATI's.¹¹

Several publications indicate that low IFX trough levels (varying from 2-3.5 mg/L) may increase the risk of flare of disease symptoms and inflammation. Low trough levels are associated with (clinical) parameters like high C-reactive protein (CRP) levels, male sex and higher albumin levels.¹²⁻¹⁶ IFX levels ≥ 3 mg/L at the start of a maintenance regime appeared to be predictive for sustained response to IFX.^{9,17} It has also been demonstrated that the achievement of endoscopic healing requires even higher IFX trough levels.¹⁸

Therefore therapeutic drug monitoring (TDM) based on IFX trough levels and antidrug antibody level measurements has the potential to play an important role in the optimization of anti-TNF-alpha treatment.^{6,19} Currently several studies designed to dose IFX based on trough levels are ongoing. To be able to predict the IFX serum levels and optimize the IFX dose based on serum level the use of a pharmacokinetic model is of great importance. Furthermore the costs in IBD therapy are mainly driven by anti-TNF- α therapy and a strategy to optimize IFX therapy and avoid unnecessary treatment is desirable.²⁰

The population pharmacokinetics (popPK) of IFX have been described earlier for patients with ankylosing spondylitis, rheumatoid arthritis and IBD.²¹⁻²³ However these models were not used to predict serum trough levels or for dose optimizing of IFX. In this paper we describe a retrospective study that was performed to develop a pharmacokinetic (PK) model for IFX in IBD patients in an out-patient setting that can be used for dose-optimization of IFX and to predict serum trough levels in this population.

Materials and Methods

Study design

This study was an observational retrospective single center study of IFX treated CD and UC patients in the years 2007-2012 conducted at the Gastroenterology department of the University Medical Center Groningen. The study population comprised patients who were treated with IFX infusion at week 0, 2, 6 as induction phase followed by a maintenance phase for at least 40 weeks in a dosage of 5mg/kg every eight weeks. Serum samples analyzed for IFX trough levels were routinely collected before infusions at weeks 0, 2, 6, 14, 22 and 54. Samples at $t=54$ were also analyzed for ATI. Patient files were reviewed by an investigator and possible relevant covariates were recorded: clinical (Harvey Bradshaw index (HBI),²⁴ Global physician scale (GPA), Mayo score, Montreal classification, extension of disease, disease duration, concomitant immunosuppressive drugs, prior IFX use, smoking, UC/CD, weight) and laboratory parameters (CRP, albumin, leukocytes). Data from the HBI were treated as continuous data. Of the initially identified possible covariates, only covariates for which values were available for at least half of the patients (21) were included in the statistical analysis. The results were divided in two periods: induction (week 0 – 6) and maintenance (week 14, 22 and 54).

Analysis of infliximab and ATI levels

To measure IFX trough and ATI levels the samples were sent to the laboratory for monoclonal therapeutics, Sanquin Diagnostics, Amsterdam, the Netherlands.

IFX trough levels were measured using an in house developed Enzyme-linked immunosorbent assay (ELISA). The lower limit of quantification was 0.002 mg/L. ATI levels were measured using a radioimmunoassay. Both methods are extensively described previously.²⁵⁻²⁷

Model development

A popPK model was developed incorporating the full dosing history and concentration measurements of all patients. A two-compartment model, also used in literature, was used as starting model.^{21-23,28} Due to the small size of the study cohort, it was not attempted to re-evaluate the model structure for the PK model, but model parameters were re-estimated. After initial model fitting, visual inspections of concentration-time plots showed several potential outlying data points. Therefore, using conditional weighted residuals (CWRES) from the base model, data points with CWRES > 3.5 (corresponding to values outside the 99.95% confidence interval (CI) for normally distributed data), were labeled as outlier and removed from the dataset.

A stepwise covariate modeling (scm) procedure was implemented on the base model for the parameters clearance (CL) and central volume of distribution (V_c). It was not attempted to estimate covariates on parameters describing peripheral distribution (peripheral volume of distribution (V_p) and inter-compartmental clearance (Q)) as these could only be estimated with moderate precision. In the first “forward” inclusion step of the scm, covariates were added to the base model in a stepwise fashion based on

statistical significance ($p < 0.05$). In a second “backward elimination” step, covariates were then removed from the final model obtained in the first step, if removal of the covariate did not result in a significantly ($p < 0.01$) worse fit. For both continuous and binary covariates, only linear models were considered. In the scm, continuous covariates were centered respective to the median value. For missing time-invariant covariates, the median covariate value was imputed, while for missing time-varying covariates the last known value was carried forward (LOCF), if any earlier observation was available for the individual. An effect of a covariate of less than 25% was deemed clinically irrelevant. Therefore, after the scm procedure, only covariates with a relative absolute effect size of >0.25 were retained in the full model. For continuous covariates the relative effect was defined as the estimated coefficient multiplied by 2 standard deviations of the covariate values in the patient population. A plot was implemented showing the effect of the statistically significant covariates on PK parameters, as well as the uncertainty around the estimate (“clinical relevance plot”).

Final model evaluation was performed using a visual predictive check (VPC). Relative standard errors for the parameter estimates were obtained from the covariance step in NONMEM. For the final full model, a bootstrap analysis using 1000 samples was implemented to obtain non-parametric estimates of uncertainty in parameter estimates (95% CI).

Simulation

Monte Carlo simulations were implemented to study expected drug concentration profiles for a clinical patient population. Simulation results were stratified by covariates that were identified as significant / relevant in the covariate analysis. Simulations were performed for three dose levels (300, 400, 600 mg), for three dosing schedules in the maintenance phase (dosing every 8, 12, or 16 weeks) and using an initial loading phase (dosing at 0, 2, 6 wks). Patients were assumed to be on steady state after 3 doses in the maintenance phase. Simulation of the Harvey Bradshaw index in patients was done using a parametric distribution. The current data best supported a log-normal distribution, with mean 1.96 and standard deviation 0.53 (both on log-scale).

Software

Models were implemented in NONMEM (version 7.2, ICON Development Solutions), with Pirana, PsN and R/Xpose as modeling environment.²⁹ The first order conditional estimation method with random effects interaction was used throughout the analysis. Data handling, generation of plots, and simulations were performed using R (version 3.0.0 or higher, <http://cran.r-project.org/>).

Endpoints

The primary objective of this retrospective study was to develop a pharmacokinetic model for IFX in IBD patients that can be used to optimize IFX dosing in an out-patient setting.

Results

Data from 42 individuals were available. All patients were still considered as responders to IFX-therapy at T = 54 weeks and were in clinical remission. For most patients, six samples were available for analysis (t=0 included), which resulted in a total of 188 IFX serum levels available for analysis. None of the IFX measurements were below the lower limit of quantification for the IFX assay. After initial model fitting, five measurements were identified as outliers and were removed from the dataset. A summary of patient demographics and covariate values is shown in table 1. Median CRP levels at baseline and at week 54 were 5 mg/L (range 5-105) and 5 mg/L (range 5-38), $p=0.138$, respectively. The median GPA score at baseline was 2 (range 1-3) and 0 (range 0-2) at week 54. The Harvey Bradshaw index declined from median of 6 (range 3-24) at baseline to median of 2.5 (range 0-9) at week 54, $p<0.001$. There were no significant differences between HBI, CRP, and albumin between males and females and between smokers and non-smokers.

IFX trough and ATI levels

Figure 1 and table 2 show a summary of the measured IFX trough levels. All patients had detectable IFX trough levels however a large interindividual variation was observed. In the induction phase 77% of the female and 95% of the male patients had an IFX trough level ≥ 3 mg/L after 3 infusions which decreased to 46% in the female and 30% in the male patients at T=54 weeks in the maintenance phase. Two patients had developed ATI at week 54. Median IFX concentrations at week 2 and week 54 were 34 (range 4-62) and 3 (range 0-25), $p<0.001$, respectively. There was a significant correlation for CRP at baseline and IFX trough level at week 2 ($R=0.408$, $p=0.010$), but not for IFX trough level at week 54. There was no significant difference in IFX trough levels at week 2 and 54 between smokers and non-smokers.

Model development

Reasonably good fit was obtained with the base model. Even when using the parameter estimates from Fasanmade *et al.*,²³ but re-estimating only residual error magnitude, the estimates for the residual error components were lower than reported in the original publication, and evaluation of individual plots revealed reasonable fit. However, re-estimation of the model parameters of the base model resulted in a very significant improvement in fit ($p<0.001$). Parameters were estimated with good precision (%) as is shown in table 3. Especially the parameters describing drug distribution were considerably different from those reported by Fasanmade *et al.*²³ A 40% (increase in CL in the maintenance phase was observed compared to the induction phase. There was no significant difference in CL between patients with UC and CD (34 vs 42%).

Covariate model

Treatment period was implemented manually as a covariate before implementation of the scm, and showed a significant improvement in fit ($p<0.001$). In the forward step of the scm, 4 additional covariates were identified as statistically significant (ATI,

Table 1a. Patient demographics and covariates at baseline.

Time-invariant	Median (range)/ numbers in cat.	Missing	Time-varying*	Median (Range)	Missing
Weight (kg)	75 (51–145)	-	Albumin (g/L)	41 (33–50)	1
Age (year)	44 (19–80)	-	CRP (mg/L)	5.0 (5.0–105)	-
Smoking	31- / 11 +	-	Leukocytes (x 10 ⁹ /L)	5.8 (2.6–16)	-
Sex	22 F / 20 M	-	TNF-alfa (ng/L)	1191 (885–1667)	22
HBI	6 (3–24)	8			
GPA *	2 (1–3)				
Prior IFX use	40- / 2+	-			
Disease type (UC / CD)	8 / 34	-			
Baseline medication					
- Thiopurines	16- / 26+	-			
- Steroids	23- / 19+	-			
- Mesalazine	32- / 10+	-			
- Methotrexate	34- / 8+	-			

*GPA = Global physician assessment score (0 = normal, 1 = mild disease, 2 = moderate disease, 3 = severe disease)

Table 1b. Baseline immunosuppressive medication, dose and duration expressed as median (range)

Medication	Number of subjects	Dose (mg)	Duration (months)
Azathioprine	20	150 (50–300)	25 (3–360)
6-Mercaptopurine	6	88 (75–100)	5 (1–13)
Methotrexate	8	15 (12.5–25)	9 (1–72)
Budesonide	11	6 (3–9)	7 (1–108)
Prednisolone	5	30 (10–50)	1 (1–7)
5-aminosalicylic acid	10	3550 (3000–4000)	12 (3–204)
Baseline: no medication	4	-	-
Baseline: mono therapy	20	-	-
Baseline: combination therapy	18	-	-

Table 2. percentage of patients with IFX trough levels above 2.0 mg/L.

Week	No of samples	Sex	% ≥ 2.0 mg/L
0	42	Male x	0
		Female	0
2	42	Male	100
		Female	100
6	40	Male	95
		Female	82
14	41	Male	75
		Female	91
22	42	Male	70
		Female	77
54	32	Male	55
		Female	64

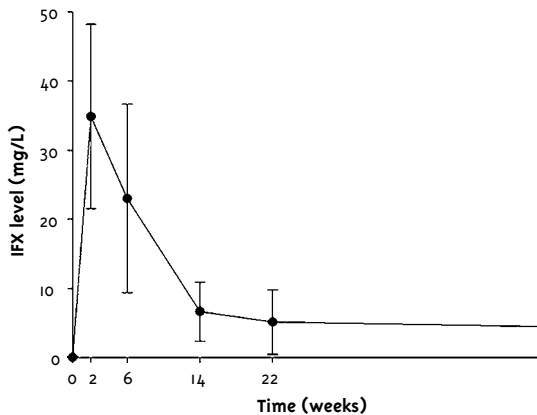


Figure 1. Summary IFX trough levels based on the available serum samples of 42 patients (meanSD).

SEX, and Albumin (ALB) on CL, and HBI on volume of distribution (V)), which were also retained in the model during the backward elimination step. The covariate effect sizes could be estimated with reasonable precision (11-35%). The largest relative effect size was found for ATI on CL, as can be seen in figure 2. In contrast with other popPK studies for monoclonal antibodies,^{21-23,28} we did not find a relationship between bodyweight and CL or V. In fact the model showed worse fit when any of the earlier reported relationships for weight were implemented in the model. The sex of the patient was found to be a significant predictor in our study. The CL for male patients was estimated to be 35% higher than in females, a finding which has also been reported by others.¹³

Table 3. Parameter estimates for final population kinetic model of IFX.

Parameter	Parameter	Estimate (precision) mate(RSE%)	Unit	Range
CL	Clearance	0.199 (6%)	L.day ⁻¹	(0.161 - 0.228)
V _{cc}	Central volume of distribution	4.94 (10%)	L	(3.030 - 5.800)
Q	Inter-compartmental clearance	0.0618 (23%)	L.day ⁻¹	(0.038 - 0.104)
V _p	Volume of peripheral compartment	3.13 (32%)	L	(1.360 - 5.940)
ω _{CL}	BSV ^a in CL	18.0% (18%)		(7.7 - 27%)
ω _{Vc}	BSV in V _c	17.1% (31%)		(1.5 - 33%)
σ _{prop}	Proportional error magnitude	21.7% (30%)		(8.0 - 32%)
σ _{add}	Additive error magnitude	0.98 (18%)	mg/L	(0.61 - 1.54%)
θ _{period}	Increase of CL in maintenance phase	+40% (11%)		(15% - 94%)
θ _{ATI}	Effect of ATI on CL	+72% (35%)		(24% - 136%)
θ _{sex}	Effect of sex on CL	+35% (34%)		(12% - 59%)
θ _{HBI}	Effect of HBI on V	-3.6 (28%)	HBI point ⁻¹	(-7.5 - -0.4)

^a BSV = between subject variability

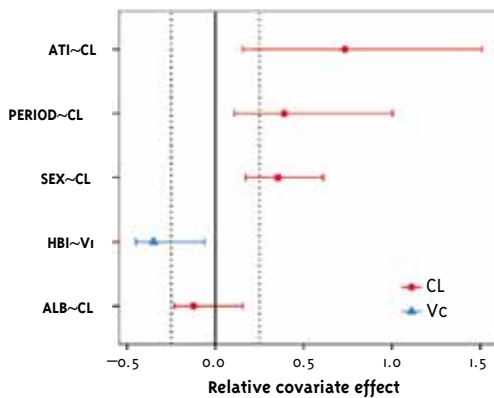


Figure 2. Plot of estimated effect magnitude on CL and V with the horizontal lines indicating the 95% CI around the estimated effect magnitude (dot). The dotted lines indicate the pre-specified clinical (ir-) relevance criterium. For continuous covariates the relative effect was defined as the estimated coefficient multiplied by 2 standard deviations of the covariate values in the patient population.

Albumin was found to be a significant predictor of PK, having a negative effect on CL, which corroborates findings by others. However, in our analysis we found the effect to have only a small clinical relevance, i.e. lower than our defined threshold of 25% relative magnitude, and the bootstrap analysis also showed that the confidence interval included 0. The covariate was therefore removed from the model.

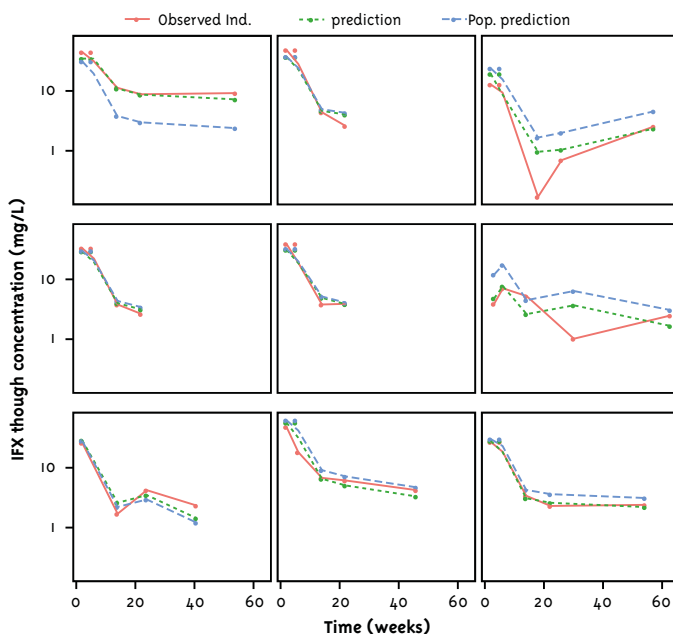


Figure 3. Model predictions (both population and individual) and observations plotted for nine representative patients. Note that for the predictions not the continuous time-course is shown, but only the expected trough concentrations.

For V , a significant and clinically relevant effect was found for the HBI at baseline, a higher value resulting in lower values of V . The final full model was thus defined as:

$$CL_i = CL_{pop} \cdot 1.345^{SEX} \cdot 1.722^{ATI} \cdot 1.40^{PERIOD} \quad [1]$$

$$V_i = V_{pop} \cdot 0.964 \cdot (HBI - 6) \quad [2]$$

in which SEX is defined as 0 for males and 1 for females, ATI is 0/1 for the presence of antibodies against IFX, and PERIOD is 0 for induction phase and 1 for the maintenance phase, HBI is the HBI at baseline.

Individual plots created using the final full model showed good correspondence between observed and model predicted values, as can be seen in figure 3 which compares the population prediction with the observed IFX concentrations for a few randomly selected patients. Goodness-of-fit plots of conditional weighted residuals versus time and predictions and of individual predictions versus observations revealed no trends, indicating an unbiased model fit (data not shown). Shrinkage in empirical Bayes estimates (EBEs) was only 3% for inter-individual random effects in CL and V , and 11% for the residual errors. The visual predictive check (figure 4) for the full model indicated that the model was able to describe the population mean PK profile as well as the between subject variability adequately, as all observed quantiles (5%, 50%, 95%) were contained within their respective prediction interval in every bin.

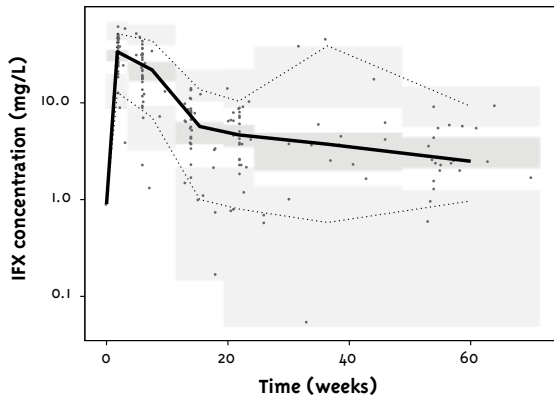


Figure 4. Visual predictive check of final model. The solid line indicates the observed median values per time interval, while the dotted lines indicate the observed 5th and 95th percentile of the observed data. The shaded areas represent the prediction interval for the median (dark grey), and the 5th and 95th percentile (light grey).

Table 4. Expected fraction of patient population below 3.0 mg/L at T=54 weeks, calculated by simulation. Dosing scenarios where expected fraction of patients under 3 mg/L is lower than 20% are bold.

Dose interval	Sex	ATI	300 mg*	400 mg*	600 mg*
q8 wks	Female	-	14%	8%	0%
		+	51%	48%	40%
	Male	-	42%	33%	14%
		+	53%	53%	52%
q12 wks	Female	-	32%	19%	9%
		+	53%	52%	49%
	Male	-	49%	44%	31%
		+	53%	53%	53%
q16 wks	Female	-	42%	31%	12%
		+	53%	53%	52%
	Male	-	52%	49%	42%
		+	53%	53%	53%

* = dosing per 8 wks, so 300mg = 450mg for q12 and 600mg for q16 regimens.

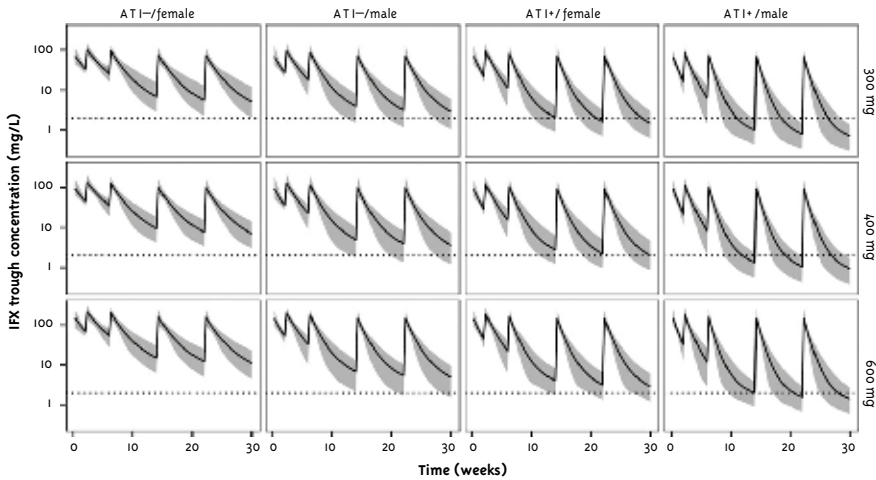


Figure 5. Monte Carlo simulation of patient population for “every 8 week” dosing, stratified by dose level and covariates ATI and sex. The horizontal dashed line shows the minimum trough level aim (3.0 mg/L).

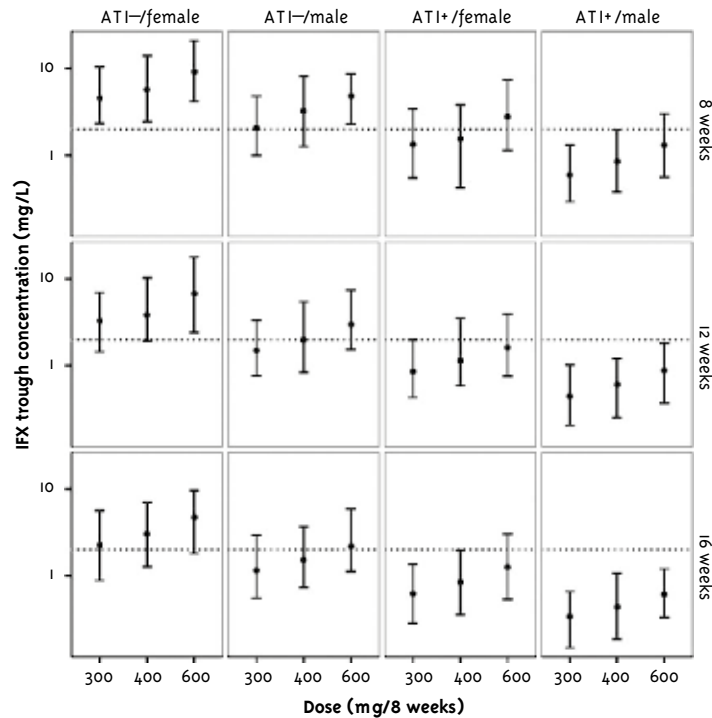


Figure 6. Monte Carlo simulation of patient population for 8, 12 and 16 week dosing, stratified by covariate. The horizontal dashed line shows the minimum trough level aim of ≥ 3.0 mg/L

Simulation

The expected time course of IFX concentrations (in a patient population similar to our cohort) is shown in figure 5, assuming every 8 week dosing in the maintenance phase. This shows that at 400 mg or 600 mg, the majority of patients that do not show ATI are expected to have trough concentrations higher than 3 mg/L.^{9,17} However, a majority of patients (either male or female) that do show ATI are expected to experience trough concentrations below the threshold.

Results from the simulation studying dosing regimens with longer dosing intervals are summarized in figure 6, which shows the expected distribution of trough levels for different dosing regimens, stratified by dose and patient characteristic, indicating that dosing every 16 weeks invariably results in the majority of patients showing trough concentrations lower than the threshold, even in those patients not showing ATI. Dosing every 12 weeks shows improved profiles, i.e. in patients that do not show ATI, this regime is expected to result in adequate levels in most patients. Table 4 summarizes the fractions of patients that are expected to have trough levels under the 3 mg/L threshold.

Discussion

Our study resulted in several interesting findings not reported in earlier PK analyses of IFX. A PK model was developed and considerably higher CL was observed during the maintenance phase compared to the induction phase and the HBI was identified as a predictor of V. Simulations from the developed model showed that dosing every 12 weeks instead of every 8 weeks can be considered in IFX treatment of patients with IBD, but only in those that do not show ATI. Considering the high percentage of patient in remission with trough levels ≤ 3.0 mg/L, dose intensification or modification in dose intervals should always be combined with clinical and/or endoscopic disease activity parameters.

Despite years of experience with the use of IFX in treatment of patients with IBD several questions still remain unanswered. These questions include which patient demographics or biomarkers are predictive of pharmacokinetics, whether PK is different between the induction and maintenance phase, and whether a longer dosing interval can result in similar adequate trough levels and similar effectiveness. Furthermore observational studies showed that approximately 25-40% of the patients experienced loss of response over time.³⁰ In some studies it was demonstrated that these patients would require an increase in dose or decrease in infusion interval.^{31,32} Katz et al concluded that dose intensification leads to a response in 47% of CD patients who lost response to standard IFX dose, but concluded that halving the infusion intervals is probably not superior to dose-doubling.³³ Kopylov et al showed that shortening the dosing interval to 6 weeks appears to be at least as effective as doubling the dose to 10 mg/kg.³⁴ The conclusions of these studies were drawn without TDM and based on clinical parameters. Therefore the question remains which role TDM can play in optimization of IFX treatment.

To be able to perform adequate TDM a PK model was developed based on models published earlier for IFX.^{21-23,28} Although this was a relatively small study, sufficient data were available to allow the development of a population PK model that could be used with confidence to perform simulations of several dosing regimens.

Not all findings from the model building process were in line with reports from previous studies. Except for the volume of distribution,³⁵ the main PK parameters were significantly different from those reported by others, especially those describing distribution to peripheral tissue. This may be attributed e.g. to differences in patient populations, or different sampling schemes. Therefore it was attempted to re-estimate all PK parameters, including Q and V₂, and the bootstrap analysis confirmed that most PK parameters could be estimated with reasonable precision (all <35%). However it must be noted that for the simulation of expected trough levels, the distribution process is not the most important component, as trough samples are always taken in the “elimination phase” of the drug.

The covariate modeling procedure identified several statistically significant. Some of these were expected *a priori*, but not all. The relationship identified in other studies between CL and patient weight was not found in our analysis. Most likely we did not find such a relationship in our study because the patients in our dataset only spanned a limited range of weight (90% CI between 60-100, with a few outliers >100kg). Other studies contained wider ranges of weights, some also including data from children. To illustrate, the relationship identified in Ref. 23 predicted only a difference of 5.6% in CL for patients with weights ranging between 60kg and 100kg, so it is unlikely that this effect would have been identified in our cohort.

The sex of the patient was a significant predictor of PK in our study, with CL 35% higher in males than in females, which was found in a previous studies as well and of similar magnitude.⁽²³⁾

Our analysis did identify a relationship between albumin levels (at baseline) and CL. However, similar to weight, our population showed only a moderate amount of variability in albumin levels, in which the interquartile difference would only result in an 8.3% difference in CL according to the relationship in Ref. 23 which was likely too low a signal to be detected in our cohort.

In our cohort only two patients showed ATI, but the effect was still found to be significant. Due to the limited number of patients with ATI, probably due to the fact all subjects had concomitant medication for IBD treatment, the effect must be interpreted with some caution. However, ATI were also identified in other popPK reports as relevant predictor of PK. The effect that was found in our statistical analysis confirmed our expectations, but it is the magnitude of the effect that may require further study in a larger population. In a study by Fasanmade²³ an effect of ATI was also identified, although it was found to be lower (29.2% vs 72%, but within the 95% CI of our current estimate).

Finally, we identified the HBI as significant covariate on V, i.e. a higher HBI was correlated with a lower V. The HBI is a measure of disease state used in the diagnosis of Crohn's disease, and includes parameters like the general well-being of the patient, the presence of abdominal pain, and the number of stools per day. An effect of HBI on

PK parameters has not been reported before, but to our knowledge, HBI has also never been tested as possible covariate in reported popPK analyses. Disease activity could influence effectiveness of biologicals such as IFX by increased utilization or fecal losses due to mucosal ulcerations. We did not include faecal calprotectin as a covariate in our analysis because in most patients this parameter was not measured routinely during this retrospective study. The statistical significance and clinical relevance of disease activity (HBI or another disease activity score with or without a fecal marker such as calprotectin) needs to be confirmed in a prospective study in a larger patient population.

The simulations from our model predict lower trough levels in patients that develop ATI. Our simulations show that almost all of these patients will have a trough level below 3 mg/L, when dosed at 400 mg. In our dataset we had only two patients that developed ATI (on 400 and 500 mg), and these patients showed trough levels in the range of 0.58 – 2.02 mg/L during the maintenance phase, corroborating our prediction that these patients are likely to show ineffective trough concentrations. In these patients a dose increase (or a decrease of the dosing interval) is warranted when disease activity is still present. However switching to another anti-TNF antibody is probably more cost effective.³⁶

Our simulations also showed that for patients without ATI, it may be considered to dose every 12 weeks instead of every 8 weeks: at dose relative to 400 mg / 8 weeks, this is expected to result in adequate dose levels (>3 mg/L) for a majority of female patients (83% at 12 weeks versus 94% at 8 weeks), while at 600 mg/8 weeks >99% are expected to show concentrations above the threshold. Unfortunately for male patients our simulations predict that dosing every 12 weeks will result in about half of the population experiencing too low trough concentrations. If dosed at an even longer time interval (every 16 weeks) the majority of patients without ATI, either male (50-72%) or female (5-39%), are expected to show trough levels <3 mg/L even if dosed at 600 mg, rendering this dosing schedule infeasible in clinical practice).

Dosing every 12 weeks instead of every 8 weeks will reduce concomitant costs to IFX therapy (laboratory, nurses, out-patient clinic etcetera) with 33% for each patient treated according to this strategy. However these aspects of therapy represent a minor part of the total costs in IBD patients.²⁰ More important is the fact that patients have to visit the hospital for IFX-related therapy only 4 times a year instead of 6 times. This is more convenient for the patients but also creates more capacity in the hospital which can be used for other purposes.

Anti-TNF-alpha therapy is expensive and therefore it is important to optimize the use of it. TDM can be used to optimize dosing regimens in patients with low, but also with high IFX levels, in order to obtain a cost-effective treatment. In this study all patients had detectable IFX trough levels and good clinical response with a significant decline of HBI, with many patients below a score of 4. However at t=54 weeks only 46% of female and 30% of the male patients had IFX trough levels of >3.0 mg/L.

Unfortunately more accurate disease activity parameters such as endoscopy or fecal calprotectin were not available for most patients. It is tempting to speculate that these patients in remission with low trough levels would be good candidates for a stopping strategy. Therefore, trough level dosing should always be combined with clinical and/or endoscopic disease activity parameters in order to avoid unnecessary dose intensification.

Conclusion

The developed pharmacokinetic model could be used to optimize TDM of IFX in IBD patients, but it needs to be confirmed in a prospective clinical trial. Simulations from the model show that dosing every 12 weeks can be considered in the treatment of patients with IBD with IFX, but only in those that do not show ATI. This strategy reduces IFX-therapy related visits to the hospital with one third. Considering the high percentage of patients in remission with trough levels ≤ 3.0 mg/L, dose intensification or modification in dose intervals should always be combined with clinical and/or endoscopic disease activity parameters.

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Letter: Infliximab therapy for patients with inflammatory bowel disease – Some unanswered questions – authors' reply

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SIRS,

In reply to the comments made by Srinivas¹: we tried to develop a model that could be used to optimise therapeutic drug monitoring of Infliximab (IFX) in inflammatory bowel disease (IBD). In the trough level plots there were indeed three of the nine randomly selected patients in whom prediction of IFX levels was observed to be more difficult than in the remaining six patients. The differences between the predicted and observed value is normal and most likely due to variance in not included covariates. For the whole population we were able to identify some parameters which influenced serum levels. For example, patients without antibodies against IFX are more often expected to have trough concentrations higher than 3 mg/L. Also male patients had 35% higher clearance than females. Although this findings are of interest, they should nevertheless be assessed in a prospective trial which is ongoing (Tailorix NCT01442025).

Regarding the issue of loss of response there are different hypotheses; factors related to the disease burden,^{2,3} patient characteristics (e.g. albumin, gender) or development of alternative pathways of inflammation.⁴

Besides these aforementioned issues, a part of the loss of response is related to immunogenicity. Antibodies are related to lower IFX trough levels and infusion reactions.⁵ Patients on IFX therapy with antibodies have a higher risk to lose response.⁶ The development of antibodies is related with use of concomitant immunomodulators. The use of these immunomodulators protects the developing of antibodies.⁷ Another risk factor of developing antibodies could be genetic background.

Furthermore, we do not believe that these patients need a high serum level IFX as also at patients with high initial levels of IFX develop ATI. Low titers of antibodies against IFX can be transient and disappear after dose increasement.^{8,9} Indeed, considering the linear kinetic model of IFX, reducing the infusion intervals of IFX might be more reasonable than doubling the dose. However, in clinical practice, these 2 strategies did not differ in clinical outcome.¹⁰

The authors' declarations of personal and financial interests are unchanged from those in the original article.¹¹

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